has been accustomed to have these attacks since his youth. To continue bromide of potass. Beef-tea and milk *ad libitum*.

7th.—Removed sutures. Union firm the whole line of the incision. Appearance of abdomen perfectly natural. Bowels regular. Delirium gone. Pulse 84, soft and compressible. Patient in every respect convalescent. There is nothing in the condition of the abdominal parts to prevent a rapid recovery.

The case above narrated by Dr. Wilder terminated fatally a few days after the conclusion of his report, death occurring from pyæmia.

There are two points in the case that should go upon the record. The first is, that the patient was subject to occasional attacks of epilepsy and had suffered some years previously from a fall through a scuttle, a distance of three stories, since which accident he had had frequent attacks of abdominal pain in the region of the liver. The *post-mortem* appearances in this region showed old peritoneal inflammation, with adhesions to the diaphragm, and a recent deposit of lymph and pus over a surface of several inches, but entirely confined to that region.

The second point is, the great relief given by puncturing the peritoneum with the trocar and allowing the accumulated gases to escape. I examined the peritoneal points of puncture *post mortem*, and found no trace of inflammation. The intestines were not touched by the trocar.

The intestine at the point of stricture showed an ecchymotic line an inch long by one fourth inch wide, but was otherwise healthy. There was considerable pus found behind the peritoneum, between it and the line of incision, which had closed by first intention. It would, perhaps, have been better to have kept the most dependent part of the wound open, so that this pus could have escaped. CALVIN G. PAGE.

PELVIC CELLULITIS.

By H. O. MARCY, M.D., Cambridgeport.

INFLAMMATION of the cellular or areolar tissue of the pelvis occurs so rarely, except in connection with the puerperal state, external violence, or uterine disease, that cases of idiopathic character are of more than ordinary interest. The obscurity of diagnosis, and departure from the usual prescribed rule of surgical non-interference, have caused me to feel that the following case was worthy of record.

Mrs. S. K., aged 33; first seen in October, 1867. Mother died of ovarian tumor. Father living. In early life, healthy. Menstruated at 16; married at 17. One child, 12 years old. Severe labor. Delivered by turning. Sick for weeks. Troubled at times with prolapsus. Has worn supporters. Never pregnant since.

In January, 1867, had pneumonia. During attack suffered from severe pain in lower part of bowels; later, noticed a swelling in left iliac region, size of an orange; quite tender and painful. Tr. iodine was applied externally by attending physician. It was thought to have disappeared, but some time later was again noticed, and has been constant since, gradually increasing in size up to the present.

In May had a discharge of several ounces of very fœtid pus by rectum. Pus has been discharged several times since from rectum, each time preceded by increased suffering. Has occasionally noticed fæces covered with pus.

Present condition, October, 1867. Pale, anæmic; much loss of flesh and strength. Appetite good, bowels inclined to diarrhœa. Sleeps poorly; complains of much pain about the tumor, shooting down leg. At times compares the suffering in severity to that of labor. Dull heavy pains in entire pelvic region.

By abdominal examination there can be distinctly felt above the pubes on left side, a hard non-fluctuating mass, rounded in outline, not differing much in size from a child's head at birth. Os uteri enlarged, thickened, rough, admitting finger.

Posteriorly and apparently continuous with the fundus uteri is felt the tumor above described, dipping down into the pelvic basin. The uterus above the cervix seems lost in the mass.

Examined from the rectum, that portion within reach feels softer, is partially separated from the mass above, by constricting fibrous bands, giving it a bilobulated appearance. Has menses quite regularly, but excessive menorrhagia, usually from two to three dozen napkins.

The patient "has been the rounds of the Doctors." The larger number have not hesitated to pronounce it cancer, and advised non-interference.

At my request the patient consulted my friend, Dr. H. R. Storer. His diagnosis was fibroid tumor of the uterus—that pressure and irritation were the probable causes

of the purulent discharges from the bowels. By his direction the os uteri was dilated with sponge tents. Interior uterus healthy.

Early in December, the pains increased, the suffering became very severe; patient confined to bed. The lower portion as felt from the rectum rapidly increased in size, and became very tender to the touch. A spontaneous discharge of pus from the bowel took place, lessening somewhat this portion of the mass.

Profiting by this hint of nature, and believing that a chronic abscess was at least part of the trouble, at my request Dr. Storer passed an exploring trocar, on the 15th, from the vagina and obtained pus; an opening was made, by which a small quantity of pus escaped. This opening closed in a few hours.

Four days later, I etherized the patient, and entered a large curved trocar posteriorly, and to the left of fundus uteri, and drew off about 20 oz. of thick, fœtid pus.

My firm unyielding tumor of 12 months standing softened and disappeared, leaving only a thick imdurated sac, which was enlarged to admit the finger, by cutting with a bistoury entered from the opening made by trocar. A profuse discharge of purulent secretion continued. The sac was washed out daily with warm water, after which a solution of carbolic acid was thrown in.

Kept the opening from closing, by applying a silver female catheter to which a piece of flexible rubber tubing was attached. This was readily retained by a napkin, allowing the patient to keep the sac empty and syringe at will.

A rapid improvement in both local and constitutional symptoms followed. Suppuration lessened; the sac gradually contracted until the catheter could not be retained.

The patient has fully regained her flesh and strength. Only a slight thickening can be felt to mark the place of the abscess.

May, 1868.

EPISTAXIS, FOLLOWING A BLOW ON THE NOSE FROM A BASE BALL.

By George Derby, M.D.

April 28th, 6, P.M.—Called to see a boy 14 years old, with violent epistaxis. History of case was as follows. Six days before, or on April 22d, he was struck by a base ball on the nose, fairly in front, and over nasal bones. There was free bleeding at the time, which stopped in about twenty minutes. During the five following days he went to school and played base ball as usual. Had several bleedings during this period, but they seem to have been not violent, and the amount of blood lost not sufficient to prevent his exercising as usual. Several times on getting up in the morning a moderate bleeding occurred. On the afternoon of the day I was called, and six days from date of original injury, while playing base ball on the Common he bled profusely, fainted and was carried home. When I reached him he was still bleeding from left nostril. On filling left anterior nares with sponge, the bleeding was at once stopped. Next morning, at 7 o'clock, it recurred in spite of the sponge plug. I then carried a small bit of sponge moistened with sol. per sulphate iron as far into the nose as could be reached with dressing forceps, bringing it out again, and plugging left anterior nares with sponge and sol. per sulphate iron. The bleeding at once stopped. This plug remained in place 48 hours, being removed on the morning of May 1st. I then washed out the nares with a solution of tannin, and supposed all trouble was over, but took the precaution to have a Belloc's canula with posterior plug at hand ready for immediate use. That night at 11 o'clock I was summoned in haste. A temporary plug of sponge and iron, prepared for such an emergency, had checked the bleeding till my arrival. On removing this the hæmorrhage from left nostril was profuse, and distinctly arterial in color. I immediately plugged the posterior nares with dry sponge, and the anterior nares with sponge and per sulphate of iron. This stopped the bleeding effectually. Pulse 120 and feeble. Gave beef tea and wine at short intervals, and tinc. mur. ferri. Next day, May 2d, no bleeding, but great discomfort from tension on nose and cheek. May 3d, tension relieved in a degree by the escape of bloody serum through lachrymal duct into the internal angle of eye.

At the end of 74 hours from the time when plugs were last introduced, a small stream of fresh blood was observed trickling down the lip and cheek, and was traced to an opening at inner side of anterior plug. This was stopped by pressure with sponge. Partially decomposed serum and mucus continued, however, to ooze from the edges of plug. Dr. Hodges saw the case in consultation at this period, and with his concurrence the anterior plug was removed. It was followed by a stream of arterial blood. Sponge with per sulphate iron was immediately thrust into the nostril, but did not entirely control it as before. Dry sponge was then crowded in until the bleeding